CSA Utilization Review: Guidelines for Best Practices

September 2020

What is Utilization Review?

Utilization Review (UR) is the formal assessment of the necessity, efficiency, effectiveness, and appropriateness of services. UR occurs at the child/family service level and in CSA, it measures the progress of the youth and family toward the goals and objectives in the Individual Family Service Plan (IFSP). UR is the process by which the IFSP and services are reviewed and recommendations provided to the Family Assessment and Planning Team (FAPT), the case manager, and/or the service provider regarding the service plan and funded services. UR is a form of checks and balances; it asks are we getting what we paid for? Are things getting better? How do we know?

UR is not a pathway to second guessing the case manager, service provider, or FAPT. UR should be a collaborative component of the service planning process. The goal of UR is not to cut costs or services, but rather to evaluate the effectiveness of services and supports. While service reductions may be an outcome of UR, in some instances UR may lead to a recommendation for an increased level, frequency, or number of services. UR should look at progress objectively to improve the outcomes for youth and families.

Is UR Required?

Yes, UR is required. Section 2.2-5206 of the Code of Virginia requires that the Community Policy and Management Team (CPMT) "establish quality assurance and accountability procedures for program utilization and funds management."

Section 2.2-5208 indicates that FAPT, "in collaboration with the family, shall provide regular monitoring and utilization review of the services and residential placements for the child to determine whether services and placement continue to provide the most appropriate and effective services for the child and family." Additionally, FAPT shall "designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies."

All localities must have a UR policy. Your policy should include a plan for how frequently UR is completed, who is responsible for completing UR, and procedures that dictate how UR is completed and recorded. The policy should also indicate who is responsible for oversight of the UR process, the manner in which oversight is managed, and how to address circumstances that deviate from the adopted practices, policies, and procedures.

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Utilization Review is part of your community's comprehensive Continuous Quality Improvement (CQI) Plan. CPMT can utilize trends collected at the child and family/service level to guide long range planning or policy decisions.

Who can do UR?

As noted above, the CPMT designates in its policies and procedures how UR is to be completed in their locality. There is great flexibility and many options for how the locality chooses to complete UR, and it is important that the community follow whatever plan they identify in their policies and procedures. The FAPT or the CSA Coordinator can complete UR. Some localities have an Identified UR specialist. UR can be a paper review of progress reports and related documents, a site visit, an interview with the provider, the youth, and family or a combination of any of these. However you choose to execute UR, you must have documentation of its occurrence.

UR can also be purchased as a service using CSA funds. UR can be purchased from the local CSB or a private entity. Remember, all services in CSA are child specific. As a result, if recommended by FAPT, UR can be placed on a youth's IFSP as a service, and the funding for this service can be approved by CPMT. In order to assure objectivity and avoid conflict, if purchasing UR from the CSB, the UR specialist should not be providing services to the youth and family. Moreover, if UR is purchased from a private entity, that entity should not be providing services to the youth and family.

Communities can also choose to contract with the Office of Children's Services for State-Sponsored UR (for non-educational residential placements). If your locality uses State-Sponsored UR for non-educational residential placements, you will still need to develop a plan for completing UR for community-based services and other levels of care.

What about IEP Placements?

Due to federal mandates associated with the special education process, Utilization Review for IEP placements should be completed by the IEP team and must be based upon the goals in the IEP. The CSA UR process for special education services must conform to special education laws and must not violate the Individuals with Disabilities Education Improvement Act (IDEIA) or state special education regulations. Local CSA programs can expect the school division to share the findings of the IEP review of the student's progress and this meets CSA Utilization Review requirements.

How Frequently Should UR be Completed?

Your local UR plan should specify the frequency with which UR is completed. State Sponsored UR is completed 60 days after the initial placement date and every 90 days thereafter.

The following is a sample review schedule:

Service Type	Utilization Review Frequency	CANS Administration
Foster care maintenance, including day care	Based on CPMT policy. Though not required to come to FAPT, best practice encourages a multi-disciplinary review	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Community-based, non-clinical services	Every 6 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Community-based, clinical services and/or a combination of two or more services	Every 3 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Intensive in-home services, Therapeutic Foster Care, ICC, or Residential (PRTF or TGH) placement	Every 3 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy and/or service/funding requirement
Private day special education services or IEP residential	Completed by the IEP review team	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Acute psychiatric (hospital)	Daily monitoring of risk and level of need	

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Quality Utilization Review is Guided by Four Principles:

Below are the four principles of quality UR and questions your local UR *might* ask.

1. Quality UR Begins with Quality, Strengths-Based Service Planning
   - UR is part of the service planning cycle. Developing a strong service plan (IFSP) is the foundation of quality UR. Service plans should incorporate all assessment data, be strengths driven, include a long-term goal as well as measurable objectives, include the voice of the youth and family, and convey a complete picture of the youth and family.
   - The long-term goal and objectives in the IFSP should align with the strengths and needs uncovered in the CANS and other assessment information.

2. Quality UR Examines ALL Elements of the Plan of Care
   - Thorough UR should examine the CANS, IFSP and Provider Treatment Plans; is there congruence? UR should consider if information on these documents is consistent.
   - UR should look to see if the services match the needs of the youth and family.
   - UR should identify if and how youth and family voice is reflected in the service plan.
   - UR should look for evidence of the strengths of the youth and family in the IFSP.

3. Quality UR Measures Progress, Provides Recommendations, and Monitors the Status of Recommendations
   - UR asks if the youth and family are making progress towards their long-term goals and objectives and looks for evidence of this progress. Are things getting better? How do you know? (e.g., youth and family engagement, changes in treatment goals and objectives, improvement in CANS scores, increase in number of strengths or social connectedness).
   - Are services being implemented as expected?
   - UR considers the barriers to progress; what changes are occurring to the service plan in order to address these needs?
   - UR looks for indicators of discharge planning.
   - UR asks questions and makes recommendations to the FAPT, Case Manager and/or service provider based upon review. These may focus on services, the IFSP, the involvement of the youth and the family or other components of the service planning process

4. UR is More Than Quality and Cost of Services
   - UR is a strategy to improve your local System of Care. Themes uncovered during UR are opportunities improve local service planning. For example, UR might identify a pattern of youth transitioning from residential to the community and then needing to return to residential; your locality could consider changes to the local service planning process.

How will local service planning improve transition planning? What changes are needed with provider relationships or community supports? What is the level of family engagement?

- Findings and trends at the service level can inform the CQI process of the CPMT. In the example above, if UR identifies a pattern of youth transitioning from residential to the community and then needing to return to residential, CPMT might consider long-range planning goals related to use of congregate care or recidivism. They also might ask if a focus on building community supports and resources is needed? (As this might help with transitioning and maintaining youth at home)
- UR can also identify bright spots of service planning, practices you want to be sure to continue. For example, we always ensure to incorporate parent voice in IFSP's as evidenced by one objective in their words.
- UR should capture family and youth satisfaction with services and the CSA process. This information should guide and improve local practices, policies and procedures.

UR is an Ongoing Cycle

Utilization Review is an ongoing process. UR is not a one-time event, but rather a continuous process that repeats itself throughout the youth and family's involvement with CSA. Feedback, recommendations, and questions raised by UR should facilitate dialogue resulting in improvements in the service delivery and outcomes for youth and families.

Tools and Resources for UR:

OCS developed a Model IFSP UR Addendum for local use. This form can be completed at a FAPT meeting or by anyone charged with completing UR. The Model IFSP UR Addendum incorporates best practices of UR identified in these guidelines. It can be found on the CSA website in the Resources Tab under Forms. A Sample (completed) IFSP UR Addendum can be found in the resources section of this document.

Your community is encouraged to develop a Family Satisfaction Survey. As noted in these guidelines, feedback from youth and family members regarding services and the local CSA process should be utilized to guide service planning as well as local policies and procedures. A sample survey is in the resources section of this document.

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CANVaS 2.0 System Reports

The CANVaS 2.0 system hosts a series of reports that may be useful for carrying out Utilization Review of children and families receiving services through CSA. The Individual Progress Report (IPR) compares a child's ratings on their Initial CANS to the two most recently completed CANS and may be converted to a graph for a visual comparison. The Permanency Report (available only for the DSS-Enhanced CANS) provides a similar comparison of Initial CANS to the two most recently completed CANS for each Caregiver rated. This report organizes the items by the five Protective Factors found in the Strengthening Families model. The Permanency Report also provides a listing of which items have "improved" from a "2" or "3" to a "0" or "1" at the last rating period so areas of improvement may be quickly noted. These reports are available to case managers who have entered at least one assessment for the child into the system.

The suite of "Longevity Reports" available to the CANVaS Local Administrator includes an additional individual child progress report (Individual Collaborative Formulation) that has multiple filters to allow more flexibility than the IPR in comparing items across assessments. The remaining four Longevity Reports provide aggregate data for the locality, so will be most helpful with community assessment and long range planning. The Item Breakout report identifies a cohort of children with treatment needs (scores of "2" and "3") by date of Initial assessment and compares to a second assessment, noting what percentage of children show the need is continuing, what percentage show improvement or worsening and what, if any, children show a new treatment need. The Multi-level Collaborative Formulation report identifies the items most endorsed in the locality as treatment needs from the Life Functioning, Emotional/Behavioral Needs, and Child Risk domains allowing for a quick look at what raters have noted are the primary needs in the community. The Strengths Development report measures whether or not the aggregate assessments reflect progress in strength-building for the children in the locality. Lastly, the Average Impact report reflects whether there is overall improvement in aggregate treatment needs.

Complete descriptions of these reports are found in the CANVaS 2.0 Report Manual, which is located in the "Documents" folder of CANVaS and on the OCS website at www.csa.virginia.gov/CANS .

Resource Materials

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Locality Utilization Review Self-Assessment

1. My locality uses needs and strengths from the CANS (and other assessments) to develop service plans

   Yes No

2. My locality develops service plans that include a long term goal and measurable objectives

   Yes No

3. The service plans my locality develops include the voice of the youth and family

   Yes No

4. My locality follows a schedule to review the service plan

   Yes No

5. We track progress towards the goal and objectives in the service plan

   Yes No

6. We monitor progress in services

   Yes No

7. The youth and family's perspective on progress (in services and towards the goal and objectives) is collected

   Yes No

8. We provide recommendations for service planning and monitor for implementation of those recommendations

   Yes No

9. We discuss and plan for discharge throughout the service planning process

   Yes No

10. We collect feedback from youth and families about the CSA process and purchased services

    Yes No

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Utilization Review Might Ask….

When Examining the Plan of Care:

- Are the IFSP, provider service plans, and assessment information congruent?
- Does the current CANS match the clinical, behavioral, and social presentation of the youth and family?
- Do the recommended/purchased services match the needs identified in assessment?
- Are the strengths and needs of the youth and family guiding the objectives and goals?
- Is there an IFSP goal and objectives?
- Is the family and youth voice and participation reflected in the IFSP?

When Measuring Progress:

- Are the youth and family progressing towards identified goals in treatment plan? How do you know? (How is progress measured?)
- If not, what are the barriers/needs towards goal achievement? What steps will be taken to meet these needs?
- Are provider treatment goals updated to reflect progress?
- Is there are clear discharge plan?
- What work is occurring to achieve the discharge plan?
- Is the IFSP updated to reflect needs, strengths and progress?
- Are there changes in CANS scores?
- Is the overall level of functioning (family and youth) improving? How do you know?
- What changes have occurred in service delivery because of UR recommendations?
- What steps has the FAPT taken to incorporate/consider recommendations from previous reviews?

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Local CSA Family Satisfaction Survey

At the FAPT meeting, I was treated with dignity and respect:

Yes No

I knew what to expect (who would be there, where they would sit, where I would sit, what would be discussed and how long it would last) before I attended the FAPT meeting:

Yes No

At the FAPT meeting, I was encouraged to share the strengths and needs of my family:

Yes No

My views about my family's strengths and needs guided decisions made at the FAPT:

Yes No

During the FAPT meeting, they used language I understood and I understood the decisions made about my family:

Yes No

I knew who to call and (how to reach them) if I had questions or concerns about CSA:

Yes No

The bright spot of CSA is/was:

The greatest challenge of CSA is/was:

What else would you like to share about your experience with CSA?

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Local CSA Family Satisfaction Survey

The services and supports provided were helpful to my family

Yes No

How have the services provided helped your family?

What concerns do you have regarding the services provided?

How is the service provider planning with you for discharge from the service?

How is the service provider connecting you to community resources?

What else would you like to share about the services provided to your family?

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(Sample) Office of Children's Services (Sample)

State Sponsored Utilization Review
Initial Utilization Review

Client: Name Replaced

DOB/Age: Age: 16

Social Security #:

CSA Contact Person: Name Replaced

CSA Locality: Name Replaced

Service Provider: Residential Facility

Admission Date: 4/23/2015

Reporting Period: Initial

Review Date: 8/2/2015

Date of Most Recent CANS Administration: 4/29/2015

Case History and Reason for Placement:

Name Replaced is in the custody of Name Replaced DSS. Name Replaced was ordered into foster care in April 2015 following a probation violation. Prior to placement in foster care, Name Replaced resided with his paternal grandmother. This was a short term placement following the disruption of placement with his maternal grandparents after their home was raided and a "meth lab" was discovered.

Submitted documentation reports that Name Replaced is on probation following an incident of "rape, sodomy, and kidnapping of a 9 year old girl." It is also written that Name Replaced has a substance abuse history and that his paternal grandmother "could not control Name Replaced and his behaviors."

Residential Facility documentation reports that "Name Replaced currently needs the Residential Facility placement to develop a trusting relationship, provide stability, supervision and structure in order to assist him with his intensive needs."

Diagnosis (if available):

None provided

Psychological Evaluation Findings (if available):

None Provided

Current Medications:

None Provided

Services Utilized in the Past:

Submitted documentation reports that Name Replaced previously attended sex offender treatment "but was removed from the treatment due to lack of participation and missing too many sessions." Prior to placement in the Residential Facility, Name Replaced was placed in detention on two occasions (January 2015 and April 2015) for probation violations.

Client and Family Strengths:

Per CANS:

Child: Family, Optimism, Educational, Talents/Interest and Involvement with Care.

Family: Involvement with Care, Residential Stability, Mental Health, Substance Use, Developmental, Accessibility to Child Care Services, Family Stress, Self-Care/Daily-Living, Educational Attainment, Legal, Financial Resources, Transportation, and Safety.

Per IFSP:

Name Replaced has a desire for a fresh start. He has expressed the need for drug treatment and the willingness to comply with services. Name Replaced's mother and grandmother are supportive of him.

Per Residential Facility Service Plan:

Name Replaced is very engaging, can articulate what he needs and is currently motivated.

Treatment Concerns/Challenges:

Submitted documentation references a serious sexual offending charge ("rape, sodomy, and kidnapping of a 9 year old girl) for Name Replaced.

Submitted documentation identifies significant substance abuse needs for Name Replaced and his family.

SERVICE PLAN REVIEW (includes Foster Care Plan, if applicable)

Include description and notes related to progress or lack of progress for each goal:

IFSP Goals/Objectives	Service Provider Goals/Objectives
Goal 1: "Name Replaced will return home to his grandmother once his behaviors have stabilized and his services are well established." **Objective**: Name Replaced will participate in all recommended services while in foster care, including sex offender treatment. Name Replaced will also maintain his relationships with his grandmother, mother, and brother.	**Goal 1**: "Name Replaced will identify reasons that he was placed on probation and reasons for substance use, and will discuss and utilize coping strategies to refrain from substance use and will follow all rules of probation." **Progress** as noted on the Residential Facility May 2015 Progress Report: Name Replaced has been very open regarding his history and reasons for substance use. He continues to be open and cooperative with KPACT and Residential Facility mother. He has followed rules of probation and is working on completing his community service.
Goal 2: "Name Replaced will complete a psychological evaluation to assess and further needs." **Objective:** Name Replaced will keep any appointments related to his psychological assessment.	**Goal 2**: "Name Replaced will follow the rules and regulations of the Residential Facility and will participate in family activities." **Progress** as noted on the Residential Facility May 2015 Progress Report: Name Replaced had followed all rules and participated in all family activities of the Residential Facility. He has increasingly interacted with the family and he appears more comfortable in the home.
Goal 3: "Name Replaced will remain substance free." **Objective:** Name Replaced will work with his Life Coach to develop healthy ways to cope instead of using drugs.	

Is the local CSA case manger participating in Service Planning/Treatment Team meetings with the service provider?
If so, how?

The submitted documentation does not provide this information.

Is service provider participating in FAPT Meetings? If so, how?

The submitted documentation does not provide this information

Discharge Plan:

The Residential Facility Plan dated May 2015 states that the "the focus of Name Replaced's placement is to help him stabilize and integrate into the Residential Facility and community while maintaining the goal to return to his mother."

Name Replaced's IFSP states that "Name Replaced will return home or step down to a TFC home once his behaviors have stabilized and he has well established services. The target date for this transition is 12/31/15."

Recommendations:

Submitted documentation states that Name Replaced's mother will need to complete substance abuse treatment and a parenting class before Name Replaced can return to her. It is written that Name Replaced's mother is "very involved and is also cooperating with DSS"; however information about her completion/enrollment in required treatment is not mentioned. Is Name Replaced's mother enrolled in substance abuse treatment? What about Name Replaced's grandparents? Submitted documentation states that his mother was in the home of his grandparents when it was raided as a "meth lab". This same documentation writes that both Name Replaced's mother and grandparents tested positive for substances. Did Name Replaced's mother reside with his grandparents? Is this the home that Name Replaced will return to? As a result of the above referenced "meth lab", one wonders about the importance of Name Replaced's grandparents also completing substance abuse treatment.

It also seems important to ensure that Name Replaced and his mother have opportunities to engage in services together prior to his return home. What opportunities exist or will exist for Name Replaced and his mother to receive family therapy or other treatment services to address the family system needs (supervision and the creation of a home that is safe, productive, and free of triggering situations and people)? In order for Name Replaced to successfully return home (maintain in the community, be free of substances, not engage in additional criminal behavior) it seems essential to ensure that Name Replaced and his mother have opportunities to engage in services together.

It is noted in the Residential Facility Progress Report that "beginning in June, DSS will begin to schedule supervised visitations with mom and grandmother"; have these visitations occurred? What needs/strengths have been uncovered as a result of these visitations?

What does Name Replaced and his mother and grandmother enjoy doing together? What are their interests? How do they spend time during visitation? Name Replaced CANS identifies Talents/Interest as a strength; what is/are his talents/strengths? What opportunities does he have to participate these activities? Are these activities that he can do with his mom/grandmother? How can his talent/interest be used to build their relationship? In addition to treatment services, deepening Name Replaced's relationship with mom and grandmother and increasing the pro-social activities they engage in seems an important component of service planning.

Submitted documentation references a serious charge for Name Replaced related to sexual offending behavior (rape, sodomy, and kidnapping of a 9 year old girl). The need for Name Replaced to participate in sex offender treatment is referenced, however, submitted documentation does not provide information regarding Name Replaced's level of engagement or progress in his sex offender treatment. Is Name Replaced compliant with this treatment? What level of progress has occurred? One also wonders about Name Replaced's risk of re-offending? When planning Name Replaced's discharge, transition, or future services, it seems essential to understand his level of progress as well as future risks related to sexual offending behavior.

Name Replaced's IFSP writes that a psychological evaluation will be completed. Has this evaluation occurred? What were the diagnostic impressions and treatment recommendations that resulted from the evaluation?

The May 2015 Residential Facility Progress Report writes that the discharge/step down date for Name Replaced is December 2015. This discharge/transition is related to the stabilization of Name Replaced's behaviors and ensuring that "he has well established services", however, measurable objectives and treatment needs are not provided. Name Replaced's most recent Residential Facility Progress Report writes of ongoing positive engagement in services. This raises the following questions:

- At what point will Name Replaced be ready for transition to a lower level of care? How will the locality/provider know that Name Replaced is ready for this transition? (What are the treatment/behavioral objectives that will indicate that Name Replaced is ready for this transition?)
- What is needed for Name Replaced to achieve these treatment objectives?
- What efforts are occurring to plan for his discharge/transition to a lower level of care?
- What will Name Replaced need in order to transition to a lower level of care?

- What is Name Replaced's vision for his transition from his residential placement? Who does he identify as his helpers achieve this vision? What does he identify as his needs?

Utilization Review Consultant: Anna Antell, LCSW

Next Review Date: November 2, 2015

CC: CPMT Chair

(Sample) Office of Children's Services (Sample)

State Sponsored Utilization Review
Subsequent Utilization Review

Client: Name Replaced

DOB/Age: Age: 14

Social Security #:

CSA Contact Person: Name Replaced

CSA Locality: Name Replaced

Service Provider: Residential Facility

Admission Date: 6/25/2015

Reporting Period: September 2015-January 2016

Review Date: 1/8/2016

Date of Most Recent CANS Administration: 12/10/2015

Case History and Reason for Placement:

The Case History and Reason for Placement was summarized in the Initial Desk Review completed in September 2015.

Diagnosis (if available):

DSM V Diagnosis:

296.89 Other specified bipolar disorder

309.81 Posttraumatic stress disorder

298.8 Other specified psychosis

Bilateral patellofemoral pain

Severe Stressors (early childhood abuse, neglect, and abandonment), current family conflict

(Per Residential Facility Individual Plan of Care dated 9/24/2015)

Psychological Evaluation Findings (if available):

No report is noted or provided.

Current Medications:

Lamictal - 150mg, twice daily

Seroquel XR- 100 mg every evening

(Per Residential Facility Individual Plan of Care dated 9/24/2015)

Services Utilized in the Past:

The Service Use History was summarized in the Initial Desk Review completed in September 2015.

Client and Family Strengths:

Per CANS:

Child: Educational, Talents/Interest, and Involvement with Care,

Family: Supervision, Involvement with Care, Knowledge, Organization, Social Resources, Residential Stability, Physical Health, Mental Health, Substance Use, Developmental, Accessibility to Child Care Services, Family Stress, Self-Care/Daily Living, Employment/Educational Functioning, Educational Attainment, Legal, Financial Resources, Transportation, and Safety.

Per IFSP:

"Name Replaced is interested in art and writing. Name Replaced is intelligent both academically and cognitively. Name Replaced understands her need for treatment and has begun work towards her treatment goals."

Per Residential Facility Individual Plan of Care:

"Gifted, intelligent, and very supportive adoptive family"

Current Treatment Concerns/Challenges:

The September 2015 Residential Facility Individual Plan of Care writes that "during this reporting period Name Replaced continues to struggle to ask for staff support at times." This document also states that "the staff encourage her to be more assertive and stop apologizing for everything as well as creating crises when affected by negative peers."

The October 2015 IFSP writes that "Name Replaced has not been calling her mother consistently while being placed at Residential Facility and has been avoiding difficult

conversations surrounding treatment. Ms. Mother has participated in a majority of family therapy via telephone."

The submitted State Sponsored UR Checklist writes that "Name Replaced continues to struggle with mood dysregulation, self-harming behaviors, and suicidal ideations and needs to remain at Residential Facility."

Current Treatment Strengths/Progress:

The September 2015 Residential Facility Individual Plan of Care writes that "during this reporting period, Name Replaced continues to interact appropriately on the unit and she is mindful of her boundaries, Also she continues to on being assertive when communicating her wants and needs." This report also writes that "unit staff reports significant progress in Name Replaced's behavior since admission as she interacts well with staff, follows redirection well, she interacts well with peers and shows signs of leadership."

The submitted State Sponsored UR Checklist writes that "Name Replaced has developed a healthy, trusting relationship with her therapist at the facility. Name Replaced is receptive to working toward her goal of expressing her emotions regarding her strained relationship with mother. She is demonstrating good coping skills during stressful situations regarding disagreements with other residents at the facility."

The October 2015 IFSP states that Name Replaced "has improved in her level of optimism and has been able to identify positives about herself. Name Replaced has also become more involved with her treatment and has identified her challenges. She has decreased her oppositional behaviors and anger." This document also writes that "Name Replaced reported that she has been better about honest with her therapist and teacher, and has been honest during treatment."

GOALS/OBJECTIVES REVIEW (includes Foster Care Plan if applicable)

Include description and notes related to progress or lack of progress for each goal:

ISFP Goals/Objectives	Provider Goals/Objectives
Long Term Goals: 1. Name Replaced and her family will communicate by expressing their feelings to each other in a healthy and appropriate manner. 2. Name Replaced will develop appropriate coping strategies to express her emotions and feelings and use them in her daily life. 3. Name Replaced will eliminate self-harm behaviors and suicidal ideations	**Goal 1**: Name Replaced will be able to cope effectively without engaging in suicidal or self-injurious thoughts/behaviors (including withholding, bingeing, and purging food) within 90 days of discharge. **Objectives:** Use effective communication by consistently verbalizing her needs. Complete Chapter 3 in DBT skills workbook. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Name Replaced has identified desire to increase ability to ask for what she needs in place of shutting down or becoming overwhelmed with emotion. Continue work on DBT skills. Interpersonal effectiveness with regard to mindfulness in conversation will be a focal point.
	Goal 2: Name Replaced will externalize thoughts and feelings related to trauma/stress so as to no engage in any verbal/physical aggression or property destruction within 90 days of discharge. **Objectives;** Ability to follow first prompt 75% of the time. Identify and practice verbalizing 3 positive affirmations. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Name Replaced has earned and maintained level 5 of 5. Name Replaced has expressed anxiety about being able to follow staff's directions and would like to be encouraged to do so over the next review period. Name Replaced has processed challenges and reports a readiness and willingness to begin developing positive affirmations to support positive self-esteem.

	Goal 3: Name Replaced will appropriately express her thoughts and feelings as well as implement assertiveness skills with her family instead of holding her feelings inside until she reacts aggressively or with deception 90 days prior to discharge. **Objectives:** Name Replaced and her mother will process Name Replaced's emotional block to treatment progress. Name Replaced will practice externalizing thoughts and feelings by using "I" statements and appropriate eye contact. Name Replaced will initiate discussion of at least one treatment goal-related topic during weekly family therapy sessions. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Name Replaced and her mother begun to identify emotional blocks. Name Replaced acknowledges that she often tries to find the "right" answer rather than speaking authentically.

Is the local CSA case manger participating in Service Planning/Treatment Team meetings with the service provider? If so, how?

Submitted documentation indicates that the CSA Case Manager participates in Treatment Meetings by phone.

Is service provider participating in FAPT Meetings? If so, how?

Submitted documentation indicates that the provider participated in FAPT by phone.

Discharge Plan:

Name Replaced's IFSP writes that "Name Replaced indicated to the team that she will be ready to return home when she is able to be honest with herself and others, more confidence in herself and her ability, not allowing her past to define her and continuing to apply what she has learned."

The Residential Facility Individual Plan of Care dated 9/24/2015, states that discharge criteria are the following: "Name Replaced will be free from all self-harm (including binging/purging/

restricting) for 60 days prior to discharge. Name Replaced will be free from all aggression for a period of 60 days prior to discharge. Name Replaced will be able to use honest, effective communication with her mother in place of lying or withholding her thoughts and emotions 30 days prior to discharge. Name Replaced will participate in several successful TLOA, gradually leading up to overnight, to determine readiness for discharge."

Recommendations:

Submitted documentation provides evidence of strong progress by Name Replaced in her treatment at Residential Facility*. While it is understood that Name Replaced has additional treatment needs that require ongoing residential placement, the locality is still encouraged to begin thinking about Name Replaced's discharge from residential treatment. Given the intensity of Name Replaced's pre placement behaviors, successful discharge planning will require collaborative, deliberate, and individualized planning. Such planning will be most effective if it begins as part of Name Replaced's treatment at Residential Facility.*

Name Replaced's ability to return and maintain at home will require that she internalizes her treatment gains and can apply the skills learned at Residential Facility *in varied settings. Providing Name Replaced with opportunities to be with her family in their home and in the community provide chances to utilize these skills. Submitted documentation writes of one off campus pass for Name Replaced and her mother; has Name Replaced had additional opportunities to be outside of the residential facility with her mother?*

Name Replaced's successful return home will also depend heavily on her mother's ability to provide permanence for her. Submitted documentation describes a significant level of at-risk and self-harming behaviors by Name Replaced prior to placement at Residential Facility*. Family therapy seems a crucial service to prevent Name Replaced and her family from returning to previous maladaptive patterns upon Name Replaced's return home (thus jeopardizing Name Replaced's permanence within the family). Submitted documentation writes that "it is recommended that Mother follow therapist's recommendations for participating in person versus via phone for family therapy sessions". Has Name Replaced's mother been able to follow through with this recommendation? If not, what are the barriers to accomplishing this task? What does Name Replaced's mom and/or Name Replaced feel is needed in order for face-to-face family therapy to occur?*

Name Replaced has many strengths and documentation notes several interests for Name Replaced. When thinking about Name Replaced's discharge from Residential Facility, the locality is encouraged to ensure that Name Replaced's strengths and interests are incorporated into the discharge planning process. By nurturing Name Replaced's strengths and interests (in addition to planning for her treatment needs), the treatment team will promote Name Replaced's

resiliency and help Name Replaced to develop natural supports. Resiliency and supports will enhance Name Replaced's wellness and self-care. This writer wonders what opportunities exist or can be created for Name Replaced to participate in activities or groups related to writing, art, and poetry? Connecting Name Replaced with such activities or groups might provide opportunities for Name Replaced to develop positive social support. It also seems important to ask Name Replaced about her vision for these interests and talents; how would she like to use them? What about Tae Kwon Do and basketball? Inquiring about Name Replaced's interest to continue these activities and finding opportunities to incorporate them into transition planning seems important.

Name Replaced appears vocal and insightful about her treatment needs and progress. As a result, it seems essential that a discharge plan incorporate Name Replaced's voice. This writer wonders what Name Replaced would say discharge should look like? Meaning what is her vision for discharge? Who are her supports? What/who helps her when things are going well? Name Replaced's IFSP includes Name Replaced's perspective on when she will be ready to return home (honesty with self and others, confidence in herself and her ability, not allowing her past to define her, and continuing to apply what she has learned); this writer wonders what Name Replaced feels she needs in order to accomplish these tasks? Who does she feel can help her accomplish these things? What will it look like/how will she (and the team) know that she has return home ready (meaning how can her "vision" for returning home be measured)?

Noted actions/changes taken in response to most recent UR:

The submitted State Sponsored UR Checklist provides a response to the questions posed in the Initial UR completed in September 2015.

Utilization Review Consultant: Anna Antell, LCSW

Next Review Date: April 8, 2016

CC: CPMT Chair

CSA Utilization Review: Guidelines for Best Practices

September 2020

UR Date: select date **Client Name:** last, first

(Locality Name)
(Sample) Utilization Review Addendum to the IFSP (Sample)

Demographic Information:			
Client Name: Elizabeth Jones	**Client ID #:** (_)	**DOB:** 8/3/2006	**Age:** 14
Review Date: 4/24/2020	**Last Review Date:** Initial UR	**Reporting Period:** Initial	
Service Provider: (provider name)		**Admission Date:** 1/24/2020	
Date of Most Recent CANS: (select date)		**Date of last FAPT:** 4/5/2020	

Evaluations/Diagnoses/Medications
Evaluations: Psychological Evaluation – February 2020- Provided details regarding depression diagnosis and treatment needs.
***Diagnoses*:** Major Depressive Disorder, Recurrent, Moderate, Disruptive Mood Dysregulation Disorder, Alcohol Use Disorder, Cannabis Use Disorder, Difficulties with caregiver and school
Medications: Escitalopram 20mg, 1/day, Clonidine .2mg, nightly

Historical Information
Case History: Elizabeth was initially referred to FAPT by her CSB Case Manager following an increase in high risk behaviors such as skipping school, self-injurious behaviors (cutting), substance use (alcohol and smoking marijuana) and suicide ideation. Elizabeth's aunt (her guardian) was concerned about recent increase in frequency and intensity of Elizabeth's behaviors.

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Service History: : Elizabeth has received outpatient counseling and case management from the CSB since February 2018. Elizabeth also received medication management from the CSB and this began in June 2018. Elizabeth began IIH services in March 2019 following multiple interactions with the Emergency Services Department at the CSB and one acute hospitalization in January 2019. Despite IIH services, she was acutely hospitalized again in June 2019 and November 2019.

Rationale for Current Services: Due to the escalating concerns regarding Elizabeth's at-risk behaviors despite involvement with multiple community-based services, Elizabeth was placed in residential treatment in January 2020. In order to prepare for Elizabeth's return home, As of April 2020, Elizabeth's aunt has been connected with a Parent Coach and has been connected to the local NAMI Chapter. Elizabeth requires treatment for the at-risk behaviors (self-harm, suicide ideation, substance use) associated with her mental health diagnosis and Elizabeth's aunt needs assistance to ensure she is equipped with the necessary skills to manage Elizabeth in the home.

Youth and Family Strengths

Per the Youth: I am independent. I am a fighter. I like to draw.

Per the Family: Per Aunt: I am committed to Elizabeth. She is indeed a strong young lady.

Per the Case Manager (CANS): Elizabeth: Family- Elizabeth's aunt is invested in her care. Talent/Interest- Elizabeth enjoys drawing and plays trumpet. Spiritual/Religious- Elizabeth's aunt is very involved in their church. Elizabeth previously participate in the church youth group. Involvement with Care-Elizabeth acknowledges that she wants things to be better. Aunt: Involvement with Care, Organization, Social Resources (connected to her church), Residential Stability, Developmental, Self-Care/Daily Living, Employment, Legal, Transportation and Safety.

Per FAPT (IFSP): Elizabeth's aunt has been an advocate and caregiver for Elizabeth for many years. She is committed to Elizabeth and has always tried to find support and help. Elizabeth has interests in the arts that can be helpful in planning for her transition home.

Per the Provider: Elizabeth expresses a desire for things to get better. She wants to succeed. Elizabeth's aunt has participated in family therapy and calls Elizabeth several times per week.

Youth and Family Needs and Treatment Concerns

Per the Youth: I want to stop feeling so much pain.

Per the Family: Elizabeth needs to be stable enough that she can safely be at home and school.

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Per the Case Manager (CANS): Elizabeth: Depression, Substance Use, Self-Harm, Suicide Ideation, School Attendance and Family relationships. Aunt: Supervision, Knowledge, Physical and Mental Health (as a result of the stress related to Elizabeth's needs) and Family Stress

Per FAPT (IFSP): Elizabeth's depression needs to be stabilize and she needs to develop the inner and community resources to manage her symptoms of depression. Elizabeth needs to reduce the engagement in self-harming skills and be clean from alcohol and drugs. Elizabeth's aunt needs to increase her understanding of Elizabeth's mental health needs, the connection between her behaviors and her mental health. Elizabeth's aunt will also need support and skill development to plan for Elizabeth's return home.

Per the Provider: Ongoing treatment for Elizabeth to develop Coping Skills for depression and specifically to reduce self-harm. Ongoing SA treatment. Family therapy for Elizabeth and her aunt.

Service Plan Review:

Date of most recent treatment team: (select date)
Did youth participate? ☒Yes ☐ No
Did parent/guardian participate? ☒ Yes ☐No; if yes, ☐ in person or ☒by phone
Did case manager participate? ☒Yes ☐No; if yes, ☒ in person or ☐by phone

Goals & Objectives:

Family Goal:

For Elizabeth to return home and stay home. To understand her depression and how to help her stay safe.

IFSP Goals/Objectives	*Service Plan Goals/Objectives*
Goal/Objective 1: Elizabeth will increase her level of participation in treatment in her RTC by attending at least two groups weekly and one individual therapy session weekly. **Progress:** Elizabeth refused several group, family and individual sessions this review period. Her mood continues to fluctuate which impacts her level of engagement.	**Goal/Objective 2:** Elizabeth will return to the community with improved insight into mood instability and how it is related to behavior. **Progress:** Elizabeth's mood continues to fluctuate. She expresses a desire for improvement, but has not yet been able to engage deeply enough in treatment to facilitate change.
Goal/Objective 2: Elizabeth's aunt will participate in parent coaching twice per week in order to build engagement with her parent coach. **Progress:** New Objective, service just beginning.	**Goal/Objective 2:** Elizabeth will return to the community with increased coping skills to deal with life's stressors. She will be able to utilize these skills instead of resorting to self-harm behaviors. **Progress:** Needs to attend therapy three times/week as well as weekly self-harm group as indicated in treatment plan in order to develop needed coping skills.

Goal/Objective 3: Elizabeth will draw at least once daily. **Progress:** New Objective- Objective added at FAPT after Elizabeth shared that the "quiet time" on the milieu is hard because she is "in her head".	**Goal/Objective 3:** Elizabeth will return to community with increased knowledge of her substance use behavior to include triggers. She will return armed with positive coping skills to utilize when faced with these triggers. Elizabeth will need to be connected to a local SA group. **Progress:** Elizabeth says she will remain clean when she leaves the RTC. She has not yet been willing to acknowledge that she will need supports, skills and resources to do this.
Goal/Objective 4: (goal/objective #4) **Progress:** (progress)	**Goal/Objective 4:** Elizabeth will return to the community with improved communication, self-expression and relationship skills. This will be evidenced by increase positive communication with her aunt. **Progress:** Elizabeth's aunt calls several times a week. She has participated in family therapy. So far these sessions are more like "check-in's" and need to evolve into more treatment.

Discharge Plan/Progress Toward Discharge:	
Discharge to: Aunt's Home	**Proposed Discharge Date:** 11/1/2020
Family's involvement in discharge: Elizabeth's aunt calls several times weekly and participates in family therapy. She remains invested in Elizabeth's treatment.	
Summarize discharge planning efforts: Elizabeth's aunt has been connected with the local NAMI Chapter to build her social support network and grow her understanding of Elizabeth's mental health needs. Elizabeth's aunt has also been connected to a Parent Coach. This service will help Elizabeth's aunt to outline and plan for her needs as well as the household needs as it relates to Elizabeth's return home.	

CSA Utilization Review: Guidelines for Best Practices

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Recommendations:
It is positive that service planning is addressing both the needs of Elizabeth and her aunt. While it is clear that Elizabeth has ongoing treatment needs, her needs will not end upon completion of the RTC and it will be essential that her aunt further develop the knowledge and skills to support these needs. The CANS identifies Supervision, Knowledge, Physical and Mental Health and Family Stress as needs for Elizabeth's aunt. As a result, it seems important that Parent Coaching focus on these needs. Additionally, Social Resources is identified as a strength for Elizabeth's aunt- the team is encouraged to consider how further connection with Elizabeth's aunt's church can be part of transition planning for Elizabeth. It is also positive to see that an objective has been added to Elizabeth's treatment regarding drawing. While engagement in treatment is important, it also seems important to ensure that Elizabeth has opportunities to use her strengths; to do things that make her feel good and provide a sense of accomplishment and fulfillment. This writer wonders if Elizabeth has the necessary resources to draw? This writer also wonders if there is more information that can be learned about Elizabeth's interest in drawing; what does she like to draw? What does she use as her materials for drawing? Is it an activity she enjoys doing with others? Could drawing be an opportunity to further build or repair her relationship with her aunt? Provider documentation notes difficulties by Elizabeth with engagement in treatment. How is the RTC adjusting treatment to increase Elizabeth's level of engagement? What new treatment strategies are offered? Documentation notes ongoing fluctuations in mood; are there adjustments needed to Elizabeth's medication?

Next Review Date:
7/24/2020

Review Completed By: (name and title)